State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

December 26, 2012

Submitted electronically via www.regulations.gov

Honorable Kathleen Sebelius, Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9972-P
P.O. Box 8012
Baltimore, MD 21244-1850

Re: CMS-9972-P; Comments to Notice of Proposed Rulemaking on Patient Protection and Affordable Care Act Health Insurance Market Rules and Rate Review

Dear Secretary Sebelius:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act (Affordable Care Act) in the state -- the Department of Insurance, the Department of Managed Health Care, and the Health Benefit Exchange ("the departments") -- California submits the enclosed comments on the proposed rules for Health Insurance Market Rules and Rate Review. California appreciates the opportunity to comments on these important regulations.

California appreciates the significant effort involved in establishing the standards relating to fair health insurance premiums, guaranteed availability and renewability, single risk pools, and catastrophic plans, as well clarifying applicability to student health plans and the role of CMS enforcement with regard to the requirements of the Public Health Service Act. California also acknowledges the additions and revisions to the rate increase disclosure and review process. However, it is critical that, to the extent possible, the final market rules minimize the rate and market disruption that may occur with implementation of the Affordable Care Act's market reforms. In these comments, which are presented in chart format, the departments offer suggestions to further this goal.

In particular, California has significant concerns regarding the potential market disruption that would result from the proposed rule limiting a state's geographic rating areas to seven unless a state receives CMS approval for another approach. Due to the size and health care market diversity of our state, California would like to consider designating a larger number of geographic rating areas in order to minimize rate shock. While the proposed rule provides an approval process for a larger number, California strongly recommends the proposed rule be changed to allow states to determine their own geographic rating areas without having to first seek approval from CMS.

While we support the policy of establishing age rating bands with a maximum 3:1 ratio, we have concerns about the potential rate impact that this may have on younger individuals who are purchasing coverage in the individual market. If it is determined that the Secretary has the authority to consider state specific implementation options, we would welcome an opportunity to discuss transitional approaches.

The enclosed comments reflect the consensus of all the signatories to this letter. Should you have questions concerning our comments, please direct them to all three agencies. Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full debut of the Affordable Care Act, which the departments have all worked diligently to successfully implement.

Sincerely,

Dave Jones, Insurance Commissioner

Brent Barnhart, Director, California Department of Managed Health Care

Peter V. Lee, Executive Director, California Health Benefit Exchange

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	I. Executive Summary			
	C. Costs and Benefits			
1	70586		We solicit comments on additional strategies consistent with the Affordable Care Act that CMS or states might deploy to avoid or minimize disruption of rates in the current market and encourage timely enrollment in coverage in 2014. For example, these strategies could include instituting the same enrollment periods inside and outside of Exchanges (as proposed in this rule) or a phase-in or transition period for certain policies. Additionally, we are examining ways in which states could continue their high risk pools beyond 2014 as a means of easing the transition. Ensuring premiums are affordable is a priority for the Administration as well as states, consumers, and insurers, so we welcome suggestions for the final rule on ways to achieve this goal while implementing these essential consumer protections. (P. 11)	The overarching goal of the Department of Managed Health Care (DMHC), California Department of Insurance (CDI), and California Health Benefit Exchange (Exchange), (together "California") in implementing the Affordable Care Act's health insurance market rules is to minimize disruption of health coverage rates for consumers. To this end, California seeks flexibility in implementing these market rules in order to minimize rate and market disruption.
	III. Provisions of the Proposed Regulations			
	A. Fair health insurance Premiums (Proposed §147.102)			
	1. State and Issuer Flexibility Related to Rating Methodologies			
2	70590		We welcome comments on the areas where and the extent to which state and issuer flexibility in rating methodologies versus a more	California is concerned that the proposed rules do not afford states and issuers sufficient flexibility in rating methodologies to help mitigate

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			standardized approach is desirable.	the expected rate shock as markets transition to the ACA's rating rules. California suggests allowing states the flexibility to address these transition issues in a manner that helps to mitigate the potential impacts.
	2. Small Group Market Rating			
	No comments			
	3. Family Rating			
3	70591, 70611*	**§ 147.102(c)** Application of variations based on age or tobacco use. With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(1)(iii) and (a)(1)(iv) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage. (1) Per-member rating. The total premium for family coverage must be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under age 21 must be taken into account.	We solicit comments on the use of the per-member build-up methodology for individual and small group market coverage. In addition, we request comments on the appropriate cap, if any, on the number of child and adult family members whose premiums should be taken into account in determining the family premium and the appropriate cut-off age for a per-child cap (for example, whether this should be aligned with the extension of dependent coverage to age 26 instead).	California requests modification of the proposed rule to allow state flexibility to adopt family tiers. California law currently in effect for small groups (and which will continue after 2014 for grandfathered health plans) allows using no more than the following family size categories: 1) single, 2) married couple (or registered domestic partners), 3) one adult and child or children; 4) married couple (or registered partners) and child or children. Finally, California requests clarity regarding rating for family members who reside in different geographic rating areas, for example, in the case of a dependent who attends school in another location.
	4. Persons Included Under Family Coverage			
4	70592	**§147.102 Fair health insurance**	We request comments on whether	California requires state flexibility in

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	70611*	**premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: (i) Whether the plan or coverage covers an individual or family. …	the final rule should specify the minimum categories of family members that health insurance issuers must include in setting rates for family policies, or whether we should defer to the states and health insurance issuers to make this determination. We also request comments on the types of individuals who typically are included under family coverage currently, including types of covered individuals who would not meet the classification of tax dependents. We note that any family member not covered under a family policy would be eligible for an individual policy pursuant to guaranteed availability of coverage under PHS Act section 2702.	defining family members. The final rule should allow states to define a family member to include a registered domestic partner. Under California law (Family Code Section 297.5), registered domestic partners must be treated the same as spouses.
	5. Rating for Geography			
5	70592 70611*	**§147.102 Fair health insurance premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: … (ii) Rating area, as established in	We solicit comments on the maximum number of rating areas that may be established within a state and the potential standards for determining an appropriate maximum number.	California would strongly prefer that the final rule not establish minimum geographic size and minimum population requirements for rating areas. If the final rule establishes these requirements, the final rule must allow states to request federal approval for more than seven rating areas in order to minimize disruption of rates. California enacted 2012 conforming legislation that established a greater

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		accordance with paragraph (b) of this section.		number of geographic rating areas than the seven in the proposed rule, AB 1083 (Chap. 852, Stats. 2012). California requires this number of rating areas due to the state's large population, large geographic area, diversity of rural and metropolitan areas, the established health care systems in various counties, and the fact that California's health plans and health insurers have not historically had the same geographic rating areas. Without state flexibility in this area, a significant number of consumers will experience significant rate shock based solely on the creation of the new rating areas. In order to minimize rate disruption, California will request approval for a greater number of rating areas (than the seven in the proposed rule) if the proposed regulation is not changed to permit states to establish their own rating areas without seeking approval from CMS.
6	70592 70611* 70612*	**§147.102 Fair health insurance premiums.** (b) Rating area. (1) A state may establish rating areas within that state for purposes of applying this section and the requirements of title XXVII the Public Health Service Act and title	We request comments regarding the use of these proposed standards for rating areas, as well as comments regarding other options for standards for geographic divisions and other relevant factors that could be used for developing rating areas. We request	The inclusion of the requirements listed in section 147.102(b)(3) in the proposed rule impedes state flexibility. We recommend paragraphs 147.102(b)(2), (3), and (4) be deleted or modified to permit greater state flexibility. These

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		I of the Patient Protection and Affordable Care Act. A state that establishes rating areas shall submit to CMS information on its rating areas in accordance with the date and format specified by CMS. (2) If a state's rating areas are not consistent with paragraph (b)(3) of this section, or if a state does not establish rating areas, the standard under paragraph (b)(3)(i) of this section shall apply unless CMS establishes rating areas within the state applying one of the standards under paragraph (b)(3)(ii) of this section. (3) A state's rating areas will be presumed adequate if one of the following requirements are met: (i) There is only one rating area within the state. (ii) There are no more than seven rating areas based on one of the following geographic divisions: counties, three-digit zip codes, or metropolitan statistical areas/nonmetropolitan statistical areas. (4) Notwithstanding paragraph (b)(3) of this section, a state may propose to CMS for approval other existing geographic divisions on which to base rating areas or a number of rating	comments from states that already have standard rating areas regarding what changes, if any, would be necessary to meet one or more of the proposed standards and the proposed limit of having no more than seven rating areas. We also request comments on whether the final rule should establish minimum geographic size and minimum population requirements for rating areas and whether state rating areas currently in existence should be deemed in compliance with this provision.	criteria seem restrictive and unsuitable, especially for states with large, diverse markets that have not been subject to uniform rating areas in the past, and are likely to result in significant market disruption. In general, a state should have the flexibility to define rating areas in order to minimize market disruption in 2014. California legislation, AB 1083 (Chap. 852, Stats. 2012), established 19 geographic rating areas for the small group market. In addition to minimizing market disruption, a greater number of geographic rating areas than the 7 in the proposed rule also provide for greater transparency in provider network costs, which may give health plans greater ability to negotiate affordable provider arrangements. California will request approval for a greater number of rating areas if the proposed regulation is not changed to permit states to establish their own rating areas without seeking approval from CMS.

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		areas greater than seven.		
7	70593 70611* 70612*	See **§147.102 (b)** above.	We request comments on appropriate schedules and procedural considerations related to rating area designations for plan years after 2014.	Since California intends to request approval for a larger number of rating areas to minimize rate disruption, California requests the final rule include timely and clear guidance for states to submit such requests.
	6. Rating for Age			
8	70593 70595 70611*	**§147.102 Fair health insurance premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: ... (iii) Age, except that the rate must not vary by more than 3:1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under paragraph (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph and the age band in paragraph (d) of this section	Accordingly, we propose to allow rates to vary within a ratio of 3:1 for adults (defined for purposes of this requirement as individuals age 21 and older), and that rates must be actuarially justified based on a standard population for individuals under age 21, consistent with the proposed uniform age curve discussed later in this section. We request comment on this approach.	California is concerned that the proposed rules do not afford states and issuers sufficient flexibility in rating methodologies to help mitigate the expected rate shock as markets transition to the ACA's rating rules. California suggests allowing states the flexibility to address these transition issues in a manner that helps to mitigate the potential impacts.

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		applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal shall be used. Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 3:1 in connection with establishing rates for individuals who are age 21 and older. A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS.		
9	70593 70611*	**§147.102(a)(iii)** …For purposes of identifying the appropriate age adjustment under this paragraph and the age band in paragraph (d) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal shall be used….	We request comments on whether other measurement points (for example, birthdays) might be more appropriate.	California believes enrollees' and insureds' rates should not change mid-policy/plan year.
10	70593 70612*	**§ 147.102 (d)** Uniform age bands. The following uniform age bands apply for rating purposes under paragraph (a)(1)(iii) of this section: … 2) Adult age bands. One-year age bands starting at age 21 and ending at age 63.	Second, with respect to adults ages 21 to 63, we propose one-year age bands so that consumers would experience steady, relatively small premium increases each year due to age. Although five-year bands are currently common in the small group market, we are also proposing to apply the same age-band structure to the small group market to align with our proposal that the per-member rating buildup approach be used in both the individual and the small	California agrees that one-year age bands are preferable to five-year bands as a strategy to minimize rate shock. California is concerned that the proposed rules do not afford states and issuers sufficient flexibility in rating methodologies to help mitigate the expected rate shock as markets transition to the ACA's rating rules. California suggests allowing states the flexibility to address these

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			group markets. We request comment on this approach.	transition issues in a manner that helps to mitigate the potential impacts.
	7. Rating for Tobacco Use			
11	70595 70611*	**§147.102 Fair health insurance premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: ... (iv) Tobacco use, except that such rate shall not vary by more than 1.5:1 for like individuals who vary in tobacco usage. (See § 147.110, related to prohibiting discrimination based on health status and programs of health promotion or disease prevention.) Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 1.5:1 in connection with establishing rates for individuals who vary in tobacco usage. A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS.	**If a state anticipates adopting narrower ratios for tobacco use, we propose that the state submit relevant information on their ratios to CMS no later than 30 days after the publication of the final rule.**	California law, AB 1083 (Chap. 852, Stats. 2012), does not permit rating variation by tobacco use for the small group market. Allowing rating variation for tobacco use will make coverage less affordable.. Accordingly, California's "ratio" for tobacco use in the small group market is 1:1. [A1]
12	70596	See **§147.102 (a)(iv)** above.	We are proposing that states or	California supports the proposed

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	70611*		issuers have the flexibility to determine the appropriate tobacco rating factor within a range of 1:1 to 1:1.5, consistent with the wellness requirements discussed below. We seek comments on this approach.	rule's flexible approach. California has already enacted small group premium rating provisions which do not permit tobacco use rating.
	B. Guaranteed Availability of Coverage (Proposed §147.104)			
13	70597 70612*	**§ 147.104(a)** *Guaranteed availability of coverage in the individual and group market.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or group market in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.	Accordingly, beginning in 2014, even non-grandfathered "closed blocks" of business would be available to new enrollees, subject to the limited exceptions discussed below. We welcome comments on this proposal.	California seeks clarification regarding the proposed regulation's assertion that guaranteed issue across the market prohibits health insurance issuers from closing blocks of business.
14	70597 70612*	**§ 147.104(b)** (1) Open enrollment periods – (ii) Individual market. A health insurance issuer in the individual market must permit an individual to purchase health insurance coverage during the open enrollment periods described in § 155.410(b) and (e) of this subchapter, with such coverage becoming effective consistent with the dates described in § 155.410(c) and (f) of this subchapter.	We solicit comments on whether this proposal sufficiently addresses the open enrollment needs of individual market customers whose coverage renews on dates other than January 1 and whether aligning open enrollment periods with policy years (based on a calendar year) in the individual market is more desirable.	California supports consistency between the open enrollment periods in the individual market outside California's Exchange with the open enrollment periods inside California's Exchange.
15	70598	**§ 147.104(b) (2) –** *Special enrollment*	The proposed rule directs that the	California supports requiring the

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	70613*	*periods.* A health insurance issuer in the group market and individual market shall establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. Enrollees shall be provided 30 days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in § 155.420(b) of this subchapter. These special enrollment periods are in addition to any other special enrollment periods that are required under state law.	election period would be 30 calendar days, which is generally consistent with the HIPAA standard. However, we request comment as to whether another standard, such as 60 calendar days, generally consistent with the Exchange standard, is more appropriate.	election period outside the Exchange to be consistent with the federal 60-day rule standard [45 CFR § 155.420(c)] inside the Exchange.
16	70598 70613*	See **§ 147.104(b) (2)** above.	We also request comments on whether health insurance issuers in the individual market should provide to enrollees in their products a notice of special enrollment rights similar to what is currently provided to enrollees in group health plans (§146.117(c)).	California supports requiring health insurance issuers to provide enrollees in the individual market with notice of their special enrollment rights. In this regard, California recently enacted legislation, AB 792 (Chap. 851, Stats. 2012) that requires health plans and health insurers, beginning January 1, 2014, to provide a notice to individuals who cease to be enrolled in individual or group coverage that they may be eligible for reduced-cost coverage through California's Exchange or no-cost coverage through Medi-Cal

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				(California's Medicaid program). It is critical that individuals who lose coverage receive timely notice of the availability of coverage through the Exchange, since, to the extent individuals fail to obtain coverage through a special enrollment period; they may be unable to obtain any health coverage until the next annual enrollment period.
17	70598		PHS Act section 2702 does not include an explicit guaranteed availability exception allowing issuers to limit the offering of certain products to members of bona fide associations. … While the guaranteed availability exception for bona fide association coverage is not allowed under the statute, we are interested in whether and how a transition or exception process for bona fide association coverage could be structured to minimize disruption while maintaining consumer protections. We seek comment on this issue.	Given the opportunity to use association coverage as a means of risk selection, California suggests HHS issue regulations to impose some limitation on inappropriate denials. Such regulations could also include the requirement for annual filings to state regulators regarding the number of individuals who have been denied association coverage.
18	70612*-70613*	**§ 147.104(c)** *Special rules for network plans.* … (2) An issuer that denies health insurance coverage to an individual or an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer		The federal regulation states that an insurer may not offer coverage in the individual or group market, as applicable, for a period of 180 calendar days after coverage is denied. California requests clarity as to whether the "as applicable" language intends to forbid insurers

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		coverage in the individual or group market, as applicable, within the service area to any individual or employer, as applicable, for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.		only from selling in the same market in which coverage was denied, or if this is a broader prohibition against selling in any market. California further suggests that the federal regulation require the state regulator to approve the insurer's reentry into the market.
19	70613*	§ 147.104(d) Application of financial capacity limits. ... An issuer that denies group health insurance coverage to any employer or individual in a state under paragraph (d)(1) of this section may not offer coverage in the group or individual market, as applicable, in the state before the later of either of the following dates: ...		As with the network capacity exception, California requests clarity as to whether the "as applicable" language means that insurers are only forbidden from selling in the same market in which coverage was denied, or if this is a broad prohibition against selling in any market.
	C. Guaranteed Renewability of Coverage (Proposed §147.106)			
20	70613* 70614*	**147.106(b)** *Exceptions.* An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following: *(1) Nonpayment of premiums:* The plan sponsor or individual, as applicable, has failed to pay		Under proposed § 147.106, a health insurance issuer may refuse to renew or continue coverage *only* under six enumerated bases. However, federal regulations regarding the state Exchanges also permit QHP issuers to terminate coverage in additional

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		premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements. *(2) Fraud. …* *(3) Violation of participation or contribution rules. …* *(4) Termination of plan. …* *(5) Enrollees' movement outside service area. …* *(6) Association membership ceases. …*		circumstances, such as loss of eligibility for coverage in a QHP or decertification of the QHP. (45 C.F.R. 155.430.) To provide clarity, proposed § 147.106 should specifically incorporate the Exchange regulations pertaining to termination and nonrenewal of coverage under a QHP in the Exchange. Additionally, California suggests clarifying the conditions of guaranteed renewability in the group market to allow for nonrenewal based on the eligibility of enrollees and dependents (e.g., loss of employee status, divorce), and, as applicable, in the individual market. Federal regulations implementing the ACA's prohibition on rescission indicated that issuers may cancel a group enrollee's coverage based on "eligibility," such as an employee no longer meeting the group's work-hour requirements. Other statutes implicitly allow issuers to terminate or discontinue enrollment after an enrollee exhausts certain statutory eligibility requirements (e.g. exhaustion of COBRA continuation coverage or a dependent child reaching age 26). However, the lack

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				of clarity regarding eligibility-based terminations of enrollment creates ambiguity. In the absence of federal guidance, California presumes states have the authority to regulate issuers' terminations of enrollment based on "eligibility."
	D. Applicability of the Proposed Rules under PHS sections 2701, 2702, and 2703 and Section 1312(c) of the Affordable Care Act to Student Health Insurance Coverage			
	No Comments			
21	70600 70616*	**§ 156.80(a).** *Individual market.* A health insurance issuer shall consider the claims experience of all enrollee in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.	Under this proposed rule, student health insurance coverage would be included in an issuer's individual market single risk pool, as described below. Nonetheless, given the differences between the student health insurance market and other forms of individual market coverage, we solicit comment on whether the final rule should allow issuers to maintain a separate risk pool for student health insurance coverage. We also seek comment on whether the final rule should provide any modifications with respect to the generally applicable individual market rating rules in connection with student health insurance coverage.	California supports a separate risk pool for student health insurance. Including students in a single individual risk pool would likely result in a significant increase in premiums for students.
	E. Single Risk Pool (Proposed §156.80)			
21	70601 70616*	**§156.80 (d)** *Index rate.* (1) In general. Each plan year or policy year, as applicable, a health insurance issuer shall establish an	The index rate, the market-wide adjustment based on total expected payments and charges for the risk adjustment and reinsurance	In the event the PCIP extends beyond 2014, California suggests that the final rule include clarification whether a state HIPAA-guaranteed

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		index rate for a state market based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in that state.... (2) Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its index rate based only on the following actuarially justified plan-specific factors (i)... (ii)...(iii)... (iv)...	programs, and the variations for individual plans would have to be actuarially justified. Furthermore, all such actuarially justified adjustments would have to be implemented by issuers in a transparent fashion, consistent with state and federal rate review processes. We seek comment on the approach described above, and on the proposed plan specific adjustments to the index rate. This proposed rule would apply both when rates are initially established for a plan and at renewal. We expect that percentage renewal increases generally would be similar across all plans in the same risk pool, but might differ somewhat due to the permitted product differences described above. We are considering allowing additional flexibility in product pricing in 2016 after issuers have accumulated sufficient claims data. We request comments on this approach.	issue and/PCIP claim costs are included in the single risk pool for the individual market.
	F. CMS Enforcement in Group and Individual Insurance Market (Various Provisions in Parts 144 and 150)			
	G. Enrollment in Catastrophic Plans (Proposed §156.155)			
			No comments requested	
	H. Rate Increase Disclosure and Review (Part 154)			
22	70602 70615*	**§154.215 Submission of rate filing justification.** (b) The Rate Filing Justification must consist of the following Parts: (1)	We request comments through the corresponding PRA comment process on the proposed information collection authorized under §154.215,	Proposed §154.215 requires insurers to file all rate increases, regardless of size, with CMS. However, states with effective rate review programs

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		Standardized data template (Part I), as described in paragraph (d) of this section (2) Written description justifying the rate increase (Part II), as described in paragraph (e) of this section (3) Rating filing documentation (Part III), as described in paragraph (f) of this section. (c) A health insurance issuer must complete and submit Parts I and III of the Rate filing justification described in paragraphs (b)(1) and (b)(3 of this section to CMS and, as long as the applicable State accepts such submissions, to the applicable State for any rate increase....	as proposed to be amended, and the additional burden, if any, it would impose on health insurance issuers and the states.	must retain flexibility to use their own templates and formats for requesting information from insurers in order to maintain effective rate review. The proposed rule would require insurers to file rates using different templates and formats than currently provided by the state. This would be unnecessary for issuers. For states deemed to have an effective rate review program, a requirement that the rate filing be submitted to the state, but not to CMS, will provide the necessary degree of regulatory oversight that is required by the ACA.
23	70603 70615*	**§154.215 Submission of rate filing justification.** (a) If any product is subject to a rate increase, a health insurance issuer must submit a Rate Filing Justification for all products on a form and in a manner prescribed by the Secretary	We also welcome comments on the need for and impact of the extension of the reporting requirement below the review threshold and whether alternative approaches to monitoring and oversight should be considered (e.g., auditing).	Monitoring and oversight should remain with states that have an effective rate review program. Duplicating state oversight is burdensome for health insurance issuers.
24	70603 70616*	**§154.301(a)(4) CMS's determinations of effective rate review programs.** ... (xii) Other standardized ratio tests recommended or required by statute, regulation, or best practices. ... (xiv) The impacts of geographic factors and variations.	We also propose to add new paragraphs (xii), (xiv), (xv), and (xvi) to §154.301(a)(4)... Comments are solicited on the impact on states created by these proposed changes and whether there are additional factors that should be considered in reviewing rate increases starting in 2014.	Proposed paragraph § 154.301(a)(4)(xii) seems to inadvertently replace an existing factor under existing paragraph § 154.301(a)(4)(xii) regarding an issuer's capital and surplus, with a new factor regarding "other standardized ratio tests recommended or required by statute, regulation or best practices." The

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		(xv) The impact of changes within a single risk pool to all products or plans within the single risk pool. (xvi) The impact of Federal reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.		proposed rule then adds new paragraphs (xiv) through (xvi), skipping paragraph (xiii). The preamble states these new factors are additions to, rather than revisions of, the existing Effective Rate Review criteria for a state's examination of rate review filings. This appears to be an inadvertent numbering error, but the proposed section as written would delete an existing component and leave a gap in the numbering.
	IV. Collection of Information Requirements			
	A. ICRs Regarding State Disclosures [§147.102(a)(1)(iii), §147.102(a)(1)(iv), §147.102(b)(1), §147.102(c)(2), §147.102(c)(3), §147.102(e), §156.80 (c)]			
25	70603 70611* 70612 70616	**§147.102(a)(1)(iii):** A state that uses a narrower ratio (than 3:1) shall submit to CMS information on its ratio in accordance with the date and format specified by CMS. **§147.102(a)(1)(iv):** A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS. **§147.102(b)(1):** A state that establishes rating areas shall submit to CMS information on its rating areas in accordance with the date and format specified by CMS. **§147.102(c)(2):** A state that establishes uniform family tiers and	We seek comments on how many states are likely to submit their own rating and risk pooling rules.	California anticipates submitting rating and risk pooling rules.

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		corresponding multipliers shall submit to CMS information on its uniform family tiers and corresponding multipliers in accordance with the date and format specified by CMS. **§147.102(c)(3):** A state that requires premium based on average enrollee amounts shall submit to CMS information on its election in accordance with the date and format specified by CMS. **§147.102(e):** Each state must establish a uniform age rating curve for rating purposes under paragraph (a)(1)(iii) of this section and submit to CMS information on its uniform age rating curve in accordance with the date and format specified by CMS. If a state does not establish a uniform age rating curve by a date specified by CMS, a default uniform curve established by CMS shall apply in that state which takes into account the rating variation permitted for age under state law. **§156.80 (c):** A state may require the individual and small group insurance markets within a state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger of risk pools shall submit to CMS information on its election in accordance with the date		

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		and format specified by CMS.		
	B. ICRs Regarding Rate Increase Disclosure and Review (§154.215, §154.301)			
	V. Regulatory Impact Analysis			
	Other Provisions			
26	70611	**§ 144.102(c)** Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage under 45 CFR parts 144 through 148. If the coverage is offered to an association member other than in connection with a group health plan, or is offered to an association's employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is considered individual health insurance coverage for purposes of 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. If the health insurance coverage is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health insurance coverage for purposes of 45 CFR parts 144 through 148.		Proposed § 144.102(c) would provide for potentially inconsistent treatment of a group health plan with fewer than two employee participants depending on whether the plan was sold through an association or obtained directly from an issuer. This seems inconsistent with the statutory definitions in 42 USC §§ 300gg-91(e)(4) and 18024(b)(2), which define small group as 1-100 employees. It is also inconsistent with § 300gg-91(e)(1)(B), which grants states the option to treat "very small groups" (with fewer than two employee participants) as small group market coverage. This discrepancy also seems to controvert prior HHS guidance, CMS bulletins, and existing federal rate review regulations (45 CFR § 154.102) which stated that the market classification of coverage sold through an association is determined at the plan level by considering the plan's characteristics as if it were not sold through an

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				association.